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FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

Tuesday, January 11th – Thursday, January 13th, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report.

MHP INFORMATION

MHP Reviewed — San Diego

Review Type — Virtual

Date of Review — Tuesday, January 11th – Thursday, January 13th, 2022

MHP Size — Large

MHP Region — Southern

MHP Location — San Diego

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 35,583

MHP Threshold Language(s) 2020— English, Spanish, Arabic, Vietnamese, Tagalog, and Cantonese

SUMMARY OF FINDINGS

Of the six recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed all six recommendations.

California External Quality Review Organization (CalEQRO) evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent met (four of four components)
- Timeliness of Care: 100 percent met (six of six components)
- Quality of Care: 80 percent met (eight of ten components), 20 percent partially met (two of ten components)
- Information Systems (IS): 100 percent met (six of six components)

The MHP submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Preventing Crisis Service and Inpatient Utilization among Youth with Depression”, is in the second remeasurement phase and considered completed with a low confidence validation rating. The non-clinical PIP, “Connections after a Psychiatric

Emergency Response Team (PERT) Contact", is in the second remeasurement phase and considered completed with a no confidence validation rating.

CalEQRO conducted one consumer family member focus groups, comprised of a total of three participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: the MHP has a public health approach to providing services; the MHP telehealth service delivery system provides beneficiary hardware and usage assistance and prioritizes beneficiary choice in deciding on telehealth or face-to-face services; this past year the MHP has improved through-put for the continuum of crisis care and urgent access by increasing crisis services; the MHP rehospitalization rates at 7- and 30-days are significantly lower than state wide; the MHP evidenced active bidirectional communication and coordinated relationships with all scopes or practice in their Quality Improvement Committees (QIC), PIPs, administrative developments and clinical practice process developments; and, despite considerable changes and the Coronavirus Disease (COVID-19) pandemic, the MHP maintained diligence with the Electronic Health Record (EHR) implementation.

The MHP was found to have notable opportunities for improvement in the following areas: the MHP's providers evidenced wait-lists, up to weeks, for direct outpatient children's and adult service requests that are not a step down from urgent or emergent delivery systems; the Assessment of Timely Access (ATA) report, provided by the MHP, showed that the range in most areas of timeliness was longer than would be expected, and this suggests waitlists for some services; the MHP would benefit from more bidirectional communication with the Community Based Organizations (CBO's); and standardization of the contract monitoring process; the Quality Improvement (QI) Work Plan Evaluation does not provide an analysis or develop future recommendations utilizing a Quality Assessment and Performance Improvement (QAPI) process.

FY 2021-22 CalEQRO recommendations for improvement include: investigate the reasons, develop, and implement strategies, and improve wait lists for direct outpatient children and adult services; investigate reasons, develop, and implement strategies, and improve timeliness to first non-urgent service request; investigate reasons, develop strategies, and improve the QI Program Work Plan Evaluation analysis and future recommendations utilizing a QAPI process; develop detailed testing, training, data conversion, integration, support, and risk-management plans to support the outpatient cutover to the Cerner Millennium (CM); continue efforts to improve bidirectional communication with the CBO's and standardization of the contract monitoring process.

INTRODUCTION

BACKGROUND

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal Mental Health Plan (MHP). DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO (CalEQRO), to review and evaluate the care provided to the Medi-Cal beneficiaries.

Additionally, DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205.

This report presents the fiscal year (FY) 2021-22 findings of the EQR for San Diego County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on Tuesday, January 11th – Thursday, January 13th, 2022.

METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior

year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the COVID-19 pandemic. The County of San Diego is currently experiencing a behavioral health workforce crisis, which has been further exacerbated by the COVID-19 pandemic. The MHP experienced loss of staff as well as staff absences and departures due to illness, stress, and family leave or obligations. These circumstances required the MHP to adjust service delivery processes, and rapidly pivot from face-to-face to increased telehealth services and telework for staff. The MHP noted difficulty in recruiting licensed staff, partially due to ongoing statewide shortage of candidates. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- Maximizing employment opportunities has been a key goal for San Diego County Behavioral Health Services (SDCBHS) in the new Five-Year Strategic Employment Plan: Fiscal Year 2020 to 2024, which outlines a plan for continued expansion of employment opportunities for people with behavioral health issues, investment in evidence-based practices that are effective in increasing employment and identifying gaps, and potential resources to address them.
- California Advancing and Innovating Medi-Cal (CalAIM) implementation - SDCBHS supports the implementation of broad program, system, and payment reform through CalAIM. While guidance on the first phase of rollouts is currently pending from DHCS, San Diego has begun updating the medical necessity criteria in the organizational providers' handbook, training modules, and all other information platforms. SDCBHS will next be addressing the removal of DHCS Title 9 International Classification of Diseases-10 approved diagnoses lists and will ensure that the EHR is up to date and can accommodate the new requirement.
- In response to recent events that highlight nationwide issues on institutional/systemic racism, the SDCBHS Director has formed a small internal

workgroup and engaged a subject matter expert to address racial equity within SDCBHS.

- Justice involved collaborative courts based in the Central Region, Behavioral Health Court, now applies the Collaborative Court model for persons who are diagnosed with a Serious Mental Illness and who have engaged in criminal behavior in the community.
- SDCBHS has launched a new initiative, the Community Experience Project (CEP), to promote behavioral health equity. The CEP aims to identify unmet behavioral health needs and address the systemic and regional inequities that lead to these unmet needs.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2020-21

Recommendation 1: The MHP is advised to use CalEQRO TA for both PIPs throughout the design and implementation process.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In 2021, the SDCBHS met with EQRO reviewers on three occasions via teleconferencing, on February 18, May 6, and May 24. During these meetings, SDCBHS staff and researchers from the University of California San Diego (UCSD), who were implementing the PIPs, consulted with the lead reviewer on the appropriateness of interventions. The group also discussed project implementation progress and anticipated details of data collection.

- The San Diego PIP team proceeded to close out the PIPs, guided by the advice of the EQRO reviewers and presented results during the review.
- The SDCBHS PIP team consulted with the new lead reviewer on November 8 in preparation for the next PIP cycle. During this consultation, the PIP team presented some possible PIP topics and explored interventions. The team received positive feedback on the direction of the new PIPs and will be pursuing the proposed topics for the next PIP cycle.

Recommendation 2: The MHP should prioritize addressing the level of care pressure across the system that was identified by the MHP and contractor staff.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has added Augmented Service Provider Adult Residential Facilities beds at an increased rate. They also added Assertive Community Treatment (ACT) and Strengths-Based Case Management (SBCM) slots to existing programs to create more community-based pathways to care.
- The expansion of Crisis Stabilization Units, Mobile Crisis Response Teams, and school-based services across the county also served to relieve some of the pressure on outpatient programs.
- The county is using newly created dashboards to monitor capacity in the hospitals, long-term care facilities, and community-based programs.
- Despite these efforts, workforce shortages are making it difficult to transition beneficiaries to the appropriate level of care.

Recommendation 3: Review and refine data reliability and calculations for timeliness measures, particularly for urgent appointments.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Access to Services Journal (ASJ) workgroup meets regularly to break down the complex data capturing processes and implement changes prudently.
- The workgroup is specifically focused on the ASJ and its issues capturing Urgent requests by the hour. They are working on putting measures in place so that programs can log new and unscheduled clients while allowing more detailed tracking (from the time the client walks in unscheduled, until they are seen by a provider).
- These measures are meant to establish protocol in collaborating with providers monthly to ensure accuracy and access time compliance.

- The team is also in the process of completing the Report Card with reporting partner Optum and is currently working on consistent tracking of Urgent appointments for current clients.
- SDCBHS has updated the ASJ to include tracking of new/returning clients and is also working with Optum on accountability reports that will allow programs to correct errors in the ASJ.
- The SDCBHS is evaluating progress made through these continuous tracking and enhancement of timeliness metrics, and these reports are also a standing item in SDCBHS' Planning Acceptance Committee (PAC) meetings.
- The PAC includes representatives from Information Systems, Fiscal, QI, Optum, and the adult and youth systems of care (all county except for Optum).

Recommendation 4: Develop a focused, centralized QI process related to medication monitoring in order to identify system-level issues that should be addressed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The SDCBHS Quality Management (QM) unit is currently implementing on a more robust medication monitoring system with the Clinical Director's Office (CDO). Currently, reports are monitored quarterly, and results are provided to the clinical directors and the program managers.
- SDCBHS is organizing an internal Medication Monitoring Committee with QI Leadership. The BHS Medical Director and CDO representation are to review results routinely as a group and identify areas for focused improvement.
- Results are to be minimally trended by program and level of care, and further subdivided by requirement, age, and variances.
- Direct conversations with prescribers will occur, as needed, as part of performance improvement processes.

Recommendation 5: Include Optum in strategizing the complex training requirements for staff that would keep them competent on both the legacy EHR and the new Millennium platform at the same time.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP contracts with Optum to provide staff training for the current EHR. Optum will use current training protocols to transition staff to the new CM EHR platform.
- Due to COVID-19 health restrictions, Optum pivoted rapidly to replace previously face-to-face clinical and operational training with an online version. The online

training is self-paced, consisting of resource packets, videos, and practice exercises.

- Lessons learned will be incorporated into the new Configuration Management training materials that will be utilized for the anticipated Fall go-live of the Configuration Management implementation for outpatient services.

Recommendation 6: Investigate and address CBO concerns regarding inconsistencies in contract monitoring and communication with contract officers.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP made efforts to standardize the contract monitoring tools and communications covering 374 contracts monitored by 26 teams. Program contracts are assigned based on a variety of parameters and it is common for larger legal entities to have more than one contract monitor.
- The county modified their procedures to release communications to the contract monitors before they went out to the CBO's so that county staff had time to learn the internal requirements and to promote consistent responses and communication with Contractors.
- Turnover in the contract monitoring teams has been high and therefore ongoing training is continuous. Continued investigation of the contract monitoring function is warranted to ensure more consistent contract monitoring and communication with the CBO's.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For San Diego County, the time and distance requirements are 30 minutes and 15 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP is able to provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual TA is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or beneficiaries) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed. The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and Performance Measures addressed below.

ACCESS IN SAN DIEGO COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 6.2 percent of services were delivered by county-operated/staffed clinics and sites, 85.7 percent were delivered by contractor-operated/staffed clinics and sites, and 8.1 percent were delivered by network providers. Overall, approximately 78.0 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: walk-in and urgent walk-in services at regional clinics, Mobile Crisis Response Teams, school and medical referrals for children, and SDCBHS collaboration with law enforcement and the justice system. The MHP operates a centralized access and crisis line team that is responsible for linking beneficiaries to appropriate, medically necessary decentralized services.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry and/or mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 8,896 adult beneficiaries, 8,734 youth beneficiaries, and 981 older adult beneficiaries across 8 county-operated sites and 355 contractor-operated sites. Among those served, 2,718 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration, and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access, and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 1: Key Components - Access

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- The MHP has a public health approach to providing services, focusing on epidemiology, behavioral and physical health integration, and health equity. For example, they are developing a CEP to facilitate data-driven processes to identify and address unmet behavioral health needs.
- The MHP is expanding services in several areas: Crisis Stabilization Units, Mobile Crisis Response Teams, school-based service contracts, Adult Residential Facilities, ACT, and Strengths Based Case Management SBCM slots.
- The MHP is building up regional behavioral health hubs to provide chronic care and integrated coordination of care.
- The county is developing strategies to divert youth from justice-involved programs to provide more focus to behavioral health needs.
- The county has been nimble in their transitions between face-to-face and telehealth services based on the fluctuations of the prevalence of the COVID-19 cases in the county.

- The county's Cultural Competence Academy recently developed a training series for executives and higher-level management to enhance awareness along with skill-based trainings to provide culturally informed services..

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

The following information provides details on Medi-Cal eligibles, and beneficiaries served by race/ethnicity and threshold language.

Latino/Hispanic and Asian/Pacific Islander beneficiaries' utilization of services lags that of other race/ethnicity groups. Latino/Hispanic represent 40.5 percent of the eligible beneficiaries but make up only 28.6 percent of the beneficiary's served in the past year. Similarly, Asian/Pacific Islanders represent 7.7 percent of the eligible beneficiaries but make up only 4.3 percent of the beneficiary's served in the past year.

Table 2: County Medi-Cal Eligible Population and Beneficiaries Served by the MHP in CY 2020, by Race/Ethnicity

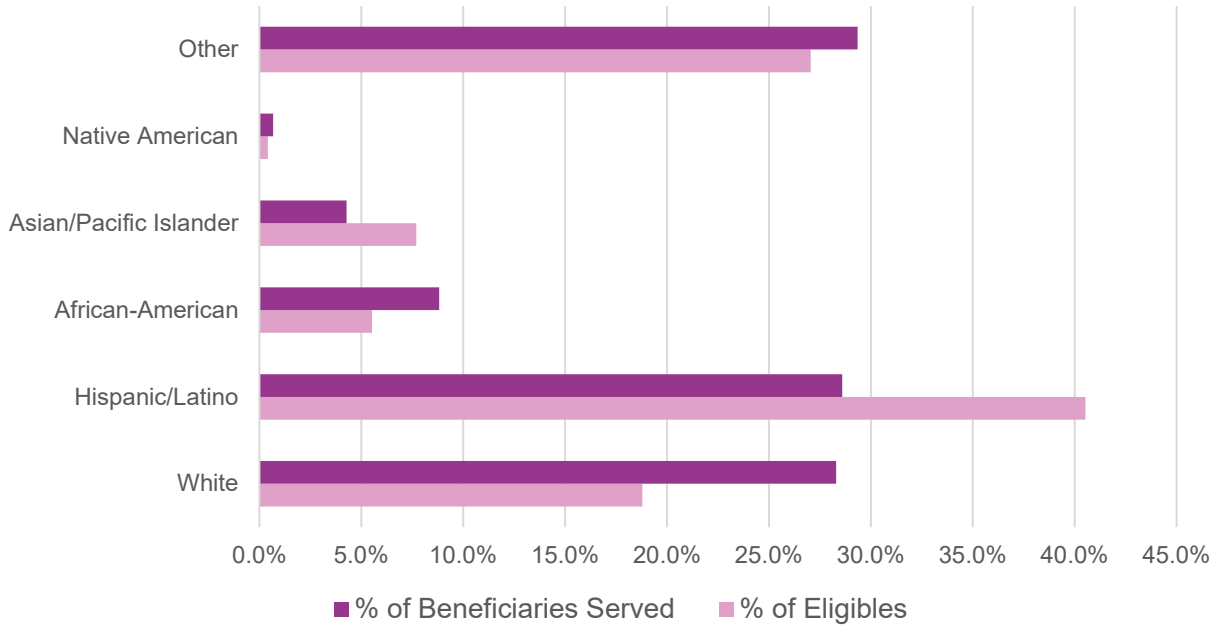
San Diego MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Eligibles**	**Percentage of Average Monthly Unduplicated Medi-Cal Eligibles**	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Annual Percentage of Medi-Cal Beneficiaries Served by the MHP**
White	161,032	18.8%	10,068	28.3%
Latino/Hispanic	347,299	40.5%	10,175	28.6%
African-American	47,339	5.5%	3,138	8.8%
Asian/Pacific Islander	65,966	7.7%	1,522	4.3%
Native American	3,523	0.4%	238	0.7%
Other	231,808	27.0%	10,442	29.3%

Total	**856,967**	**100%**	**35,583**	**100%**
The total for Average Monthly Unduplicated Medi-Cal eligibles is not a direct sum of the averages above it. The averages are calculated independently.				

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Latino/Hispanic and Asian/Pacific Islander beneficiary populations are underrepresented in receipt of SMHS. White and African-American beneficiaries are overrepresented in receipt of SMHS.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Almost one out of six Medi-Cal beneficiaries in San Diego County identifies Spanish as their primary language. This is consistent with the large percentage of Hispanic/Latino beneficiaries. In addition, the large number of threshold languages demonstrates the diversity in the county.

Table 3: Medi-Cal Beneficiaries Served by the MHP in CY 2020, by Threshold Language

San Diego MHP		
Threshold Language	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Percentage of Medi-Cal Beneficiaries Served by the MHP**
Arabic	738	2.1%
Cantonese	15	0.0%
Other Language	29,068	83.0%
Spanish	4,785	13.7%
Tagalog	81	0.2%
Vietnamese	333	1.0%
Total	**35,020**	**100.0%**
Threshold language source: Open Data per BHIN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

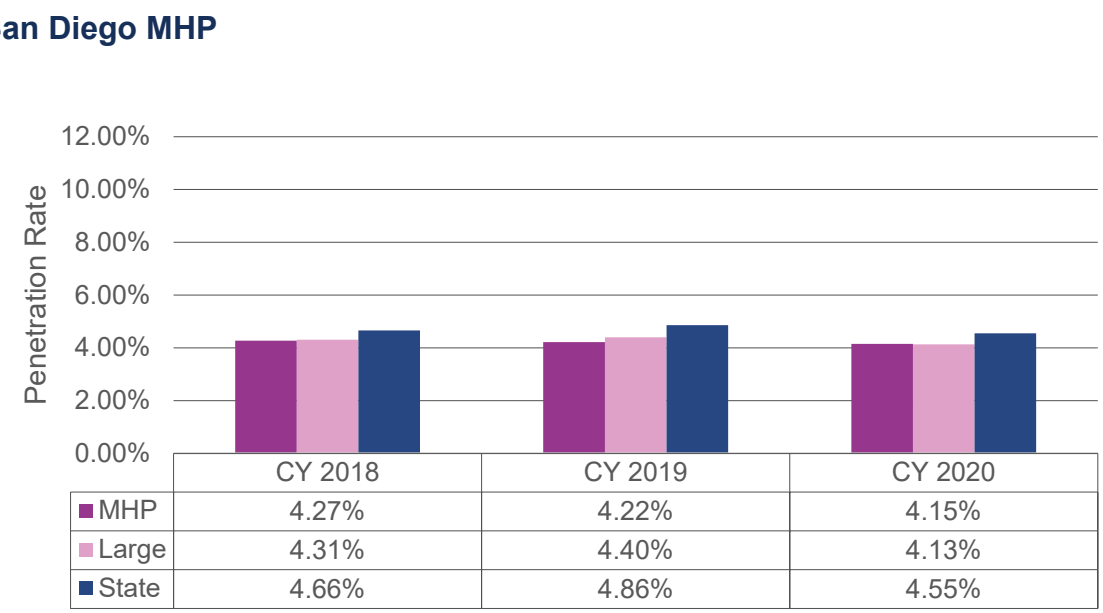
CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2020 ACA penetration rate and ACB.

Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander beneficiaries.

San Diego County's overall penetration rate is similar to other large counties, while there is more variation when looking at specific populations. The Latino/Hispanic penetration rate continues to be lower than other large counties, while the Asian/Pacific Islander penetration rate continues to be a little higher than other large counties.

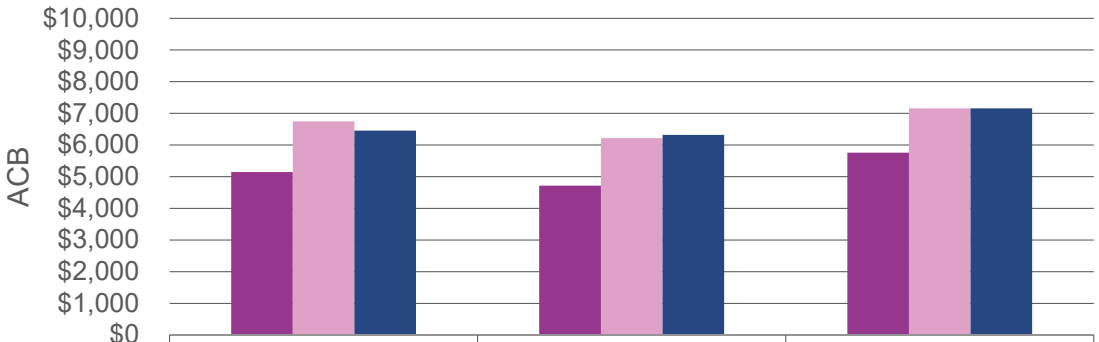
The overall ACB is lower than other large counties, while the Asian/Pacific Islander ACB is significantly lower. The FC ACB has been trending up from CY 2018-2020 and is now very close to the large county figure.

Figure 2: Overall Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	4.27%	4.22%	4.15%
Large	4.31%	4.40%	4.13%
State	4.66%	4.86%	4.55%

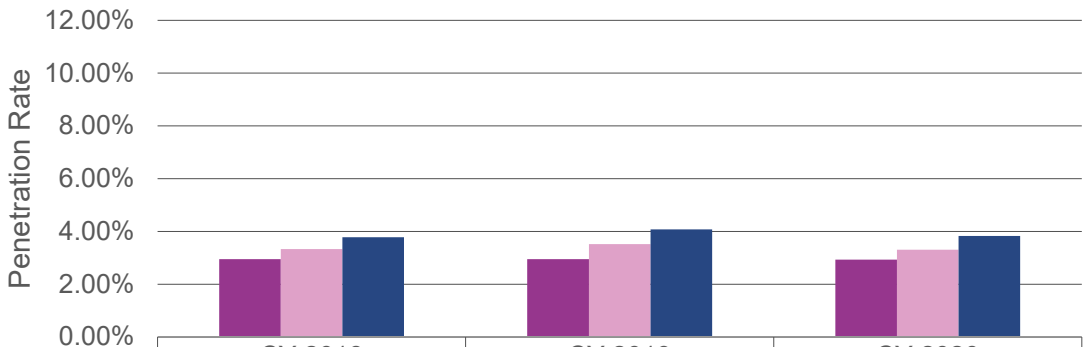
Figure 3: Overall ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$5,148	$4,717	$5,759
Large	$6,750	$6,219	$7,156
State	$6,454	$6,316	$7,155

Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

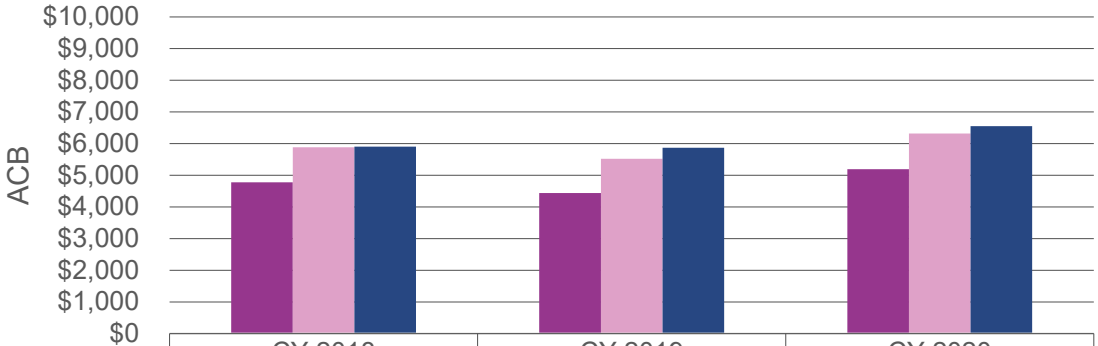
San Diego MHP



	CY 2018	CY 2019	CY 2020
MHP	2.95%	2.95%	2.93%
Large	3.33%	3.52%	3.31%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20

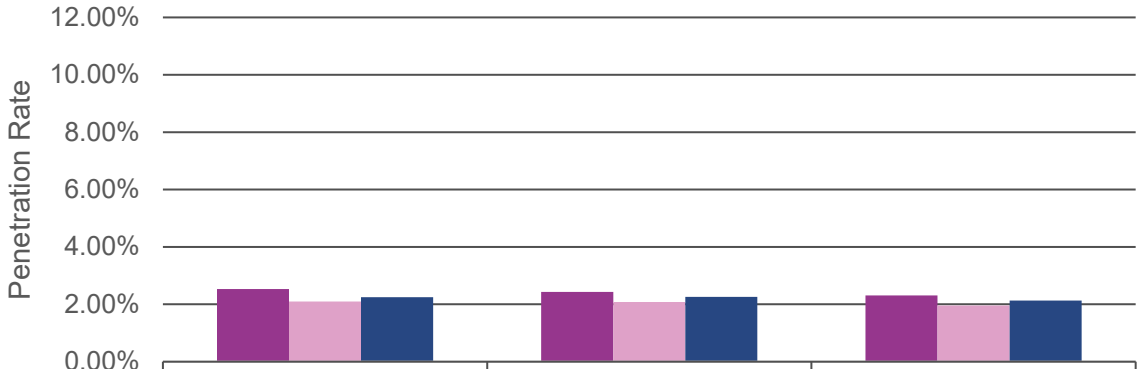
San Diego MHP



	CY 2018	CY 2019	CY 2020
MHP	$4,778	$4,437	$5,192
Large	$5,884	$5,523	$6,317
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20

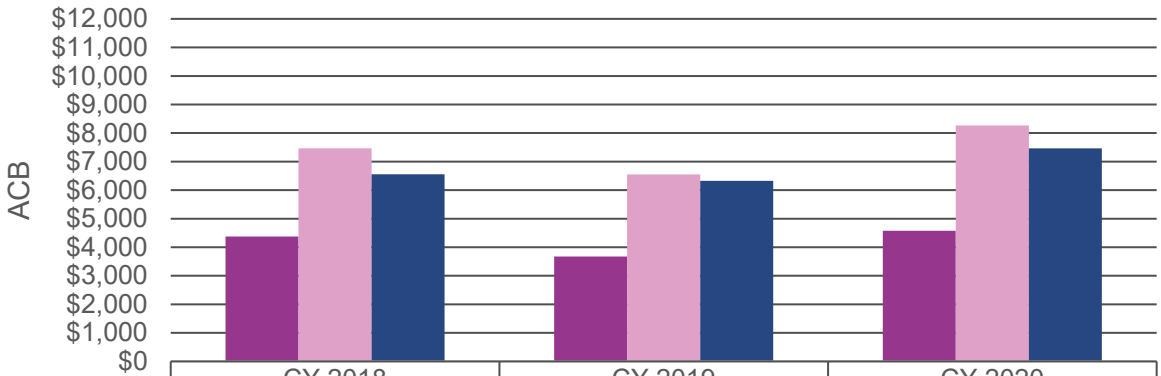
San Diego MHP



	CY 2018	CY 2019	CY 2020
MHP	2.53%	2.43%	2.31%
Large	2.10%	2.08%	1.96%
State	2.25%	2.26%	2.13%

Figure 7: Asian/Pacific Islander ACB CY 2018-20

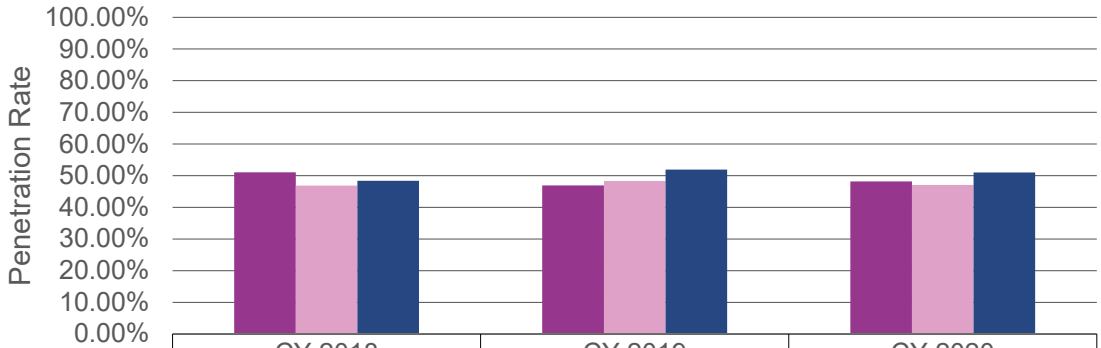
San Diego MHP



	CY 2018	CY 2019	CY 2020
MHP	$4,374	$3,673	$4,575
Large	$7,464	$6,552	$8,266
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20

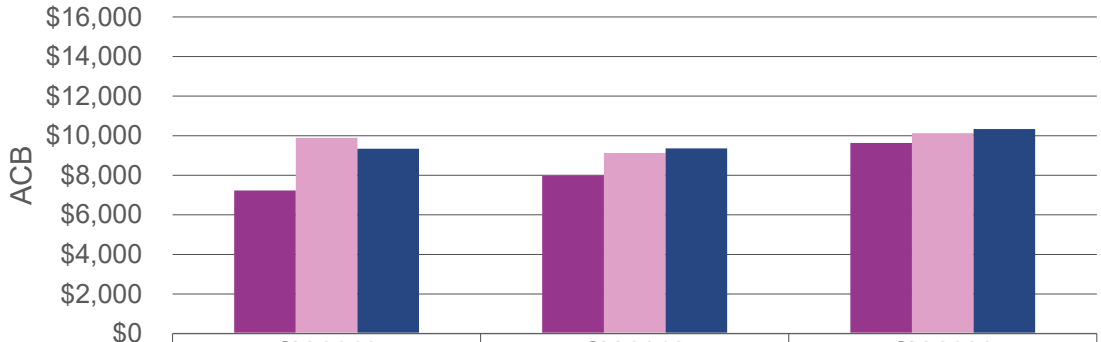
San Diego MHP



	CY 2018	CY 2019	CY 2020
MHP	51.08%	46.91%	48.18%
Large	46.87%	48.34%	47.06%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

San Diego MHP



	CY 2018	CY 2019	CY 2020
MHP	$7,235	$7,973	$9,636
Large	$9,895	$9,125	$10,129
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

San Diego County is a diverse county as demonstrated by the numbers of threshold languages: Spanish, Arabic, Vietnamese, Tagalog, Cantonese; the MHP has also added Farsi to its list of threshold languages, which was not yet an identified threshold language when CalEQRO generated the data for Table 3. The MHP strives to meet the needs of its diverse beneficiary population with bilingual staff and translation services. In addition to bilingual staff, the MHP prioritizes the recruiting of bicultural staff.

The high percentage of Latino/Hispanic beneficiaries and low penetration rate in this population suggests that there are barriers to access which warrant further evaluation.

The low Asian/Pacific Islander ACB also warrants attention.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and Performance Measures addressed below.

TIMELINESS IN SAN DIEGO COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system.

The Assessment of Timely Access report provided by the MHP showed that the range in most areas of timeliness was longer than would be expected to suggest waitlists for some services.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the Performance Measures section.

Each Timeliness Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 4: Key Components – Timeliness

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- The MHP has low psychiatric hospital readmission rates at both 7- and 30-days post hospitalization. The 30-day readmission rate is lower than the state 7-day average.
- The MHP provides timely follow-up services following psychiatric hospitalization. The Healthcare Effectiveness Data and Information Set (HEDIS) standard is seven days and San Diego has set a three-day standard for the county.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, HEDIS measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required

- Urgent Services Offered – Prior Authorization Required
- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

- Average wait time of 6.8 days from initial service request to first non-urgent appointment offered
- Average wait time of 7.6 days from initial service request to first non-urgent psychiatry appointment offered; the MHP measures this metric from the point of initial beneficiary request.
- Average wait time of 33.6 hours from initial service request to first urgent appointment offered for services that do not require prior authorization; these appointments include outpatient mental health and psychiatry services. The MHP does not require prior authorization for any urgent services.
- The MHP met their standards of no-show rates for both psychiatrists and clinicians. At the same time, clinicians reported that they were diligent in following up with clients that missed an appointment.
- San Diego only met the MHP ten-business day standard for First Non-Urgent Service Rendered half of the time. The average was 22.4 days.

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6.8 Days	10 Business Days*	84.3 %
First Non-Urgent Service Rendered	22.4 Days	10-Business Days**	50.6 %
First Non-Urgent Psychiatry Appointment Offered	7.6 Days	15 Business Days*	82.8 %
First Non-Urgent Psychiatry Service Rendered	16.5 Days	15-Business Days**	72.2 %
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	33.6 Hours	48 Hours*	87.8 %
Urgent Services Offered – Prior Authorization Required	****	96 Hours*	****
Follow-Up Appointments after Psychiatric Hospitalization	7 Days	3 Days**	31.7 %
No-Show Rate – Psychiatry	14.8 %	20 %**	n/a
No-Show Rate – Clinicians	9.8 %	15 %**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards **** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.			
For the FY 2021-22 EQR, the MHP reported its performance for the following time period: FY 2020-21.			

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained mental health professionals is critically important.

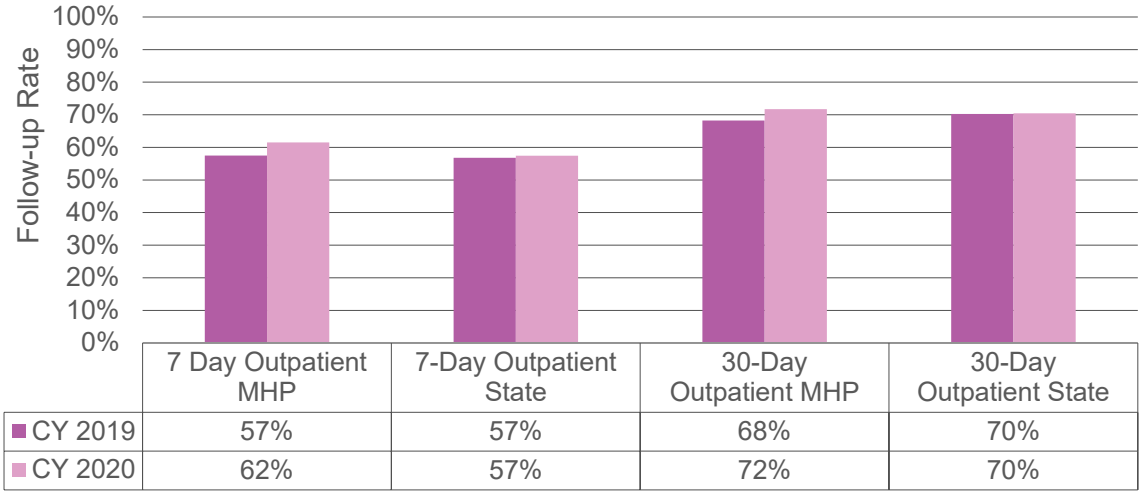
Follow-up post hospital discharge

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

In CY 2020 the MHP provided outpatient services following a post psychiatric discharge more frequently than the state average at both 7 and 30 days. The MHP-provided data showed only 31.7 percent of services met the 7-day HEDIS standard, but at the same time they have set a 3-day county standard for post psychiatric hospitalization care.

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20

San Diego MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	57%	57%	68%	70%
CY 2020	62%	57%	72%	70%

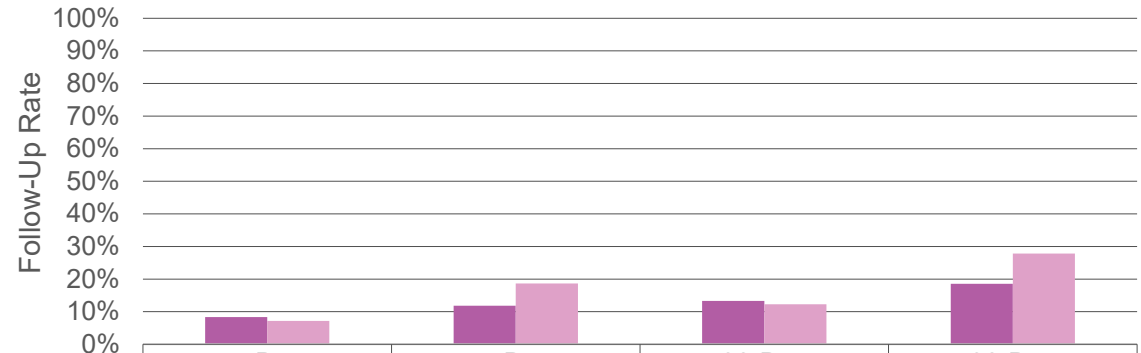
Readmission rates

The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

The MHP has low psychiatric hospital readmission rates at both 7- and 30-days post hospitalization, well below the statewide average.

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20

San Diego MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	8%	12%	13%	19%
CY 2020	7%	19%	12%	28%

IMPACT OF FINDINGS

While the county meets the first offered clinical and psychiatric appointment standard over 80 percent of the time, staff report that due to staffing shortages, scheduling ongoing appointments is increasingly difficult.

The county's low rehospitalization rate and their three-day standard for providing follow-up services following a hospital discharge demonstrates effective strategies around hospitalization. Lower readmission rates suggest positive outcomes of treatment.

Staffing vacancies, some of which were prompted by COVID-19, affected timeliness to services in CY 2020. As COVID-19 continues, the MHP will need to implement strategies to increase its capacity to provide timely services.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI program for the services furnished to beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN SAN DIEGO COUNTY

In SDCBHS, the responsibility for QI is carried by the Executive Quality Improvement Team (EQIT). The EQIT is responsible for implementing the QI Unit, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating QI activities. The QRC is a standing body charged with the responsibility to provide recommendations regarding the QI activities for mental health and substance use disorder system and the Quality Improvement Work Plan (QIWP). QICs are subcommittees of the QRC and are composed of QRC members and QI staff.

The MHP QRC is scheduled to meet at least quarterly. Since the previous EQR, the MHP QIC met four times. Of the ten identified FY 2020-21 QIWP goals, only 30 percent of the goals were met. The "Quality Improvement Mental Health Services Work Plan Evaluation FY 2020-21" data and results are documented but analysis and recommendations are routinely limited to "*SDCBHS will continue to monitor XYZ in FY 2021-22, with the intention of meeting this goal*."

The MHP uses the Milestones of Recovery Scale (MORS) as a tool to determine appropriate placement within outpatient (OP) clinics, and it uses the Level of Care Utilization System (LOCUS), for ACT and SBCM program levels of care..

The MHP utilizes the following outcomes tools: MORS, Pediatric Symptom Checklist, Sutter-Eyberg Student Behavior Inventory- Revised, Child and Adolescent Needs and Strengths (CANS), Illness Management and Recovery, LOCUS, Personal Experience Screening Questionnaire, and the Recovery Markers Questionnaire.

The MHP has a new population health unit dedicated to understanding the health status and outcome needs of the county.

The county uses Cultural Brokers and peers to enhance communication between clinicians and beneficiaries from culturally diverse traditions.

Peer employment exists across the network. It is built into CBO contracts; peers must receive training and be paid. The county seeks peer involvement in committees such as the Cultural Competence Resource Team.

Although the MHP employs peers throughout the system, there does not appear to be a career ladder nor supervisory positions available specifically for peers.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

Strengths and opportunities associated with the quality components identified above include:

- The county reported numerous cases where they used data to identify issues and unmet needs:
    - The CEP dashboard facilitates data-driven service planning and resource allocation.
    - The MHP is developing a Behavioral Health Index that includes poverty and unemployment data to identify where gaps might be emerging.
    - The county monitors unemployment and correlates the information with mental health outcomes.
    - The MHP developed a COVID-19 dashboard to identify unvaccinated beneficiaries.
- The county should continue their efforts to improve communication with the CBO's and standardize the contract monitoring process.
- The county is actively working on CalAIM initiatives including working with Blue Shield to provide Enhanced Care Management. At the same time, it is recommended that they examine how they are implementing documentation

requirements for the CBO providers to ensure they are achieving the simplification goals of the CalAIM program.

- The QM unit is currently working on a more robust medication monitoring system with the CDO. Currently, reports are monitored quarterly, and results are provided to the clinical directors and the program managers. SDCBHS is working to organize an internal Medication Monitoring Committee with QI Leadership, the BHS Medical Director and CDO representation to review results routinely as a group and identify areas for focused improvement. Direct conversations with prescribers will occur, as needed, as part of performance improvement processes.
- The MHP tracks and trends the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

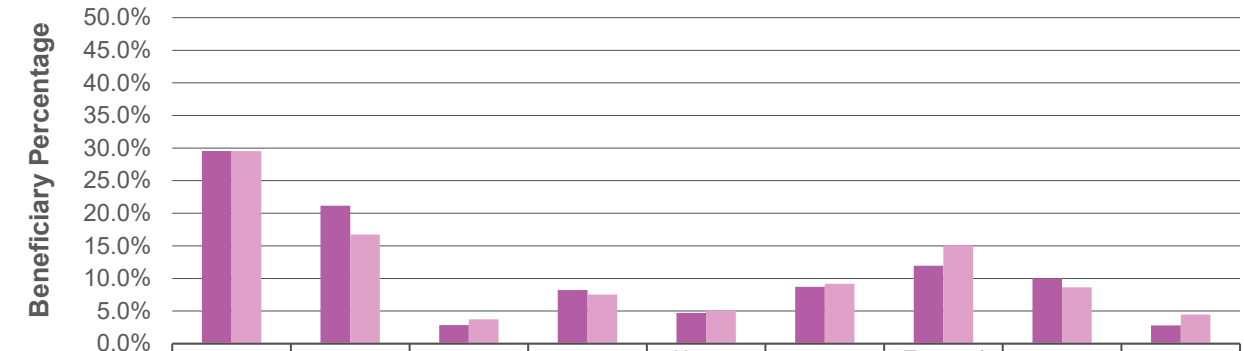
Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

Over 60 percent of beneficiaries have one of three diagnoses: depression (29.6 percent), psychosis (21.2 percent) and trauma/stressor related disorders (12.0 percent). No significant variation from corresponding statewide data is noted in San Diego's

distribution of beneficiaries served by diagnosis. The approved claims dollars by diagnosis also show no significant variation from corresponding statewide data.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

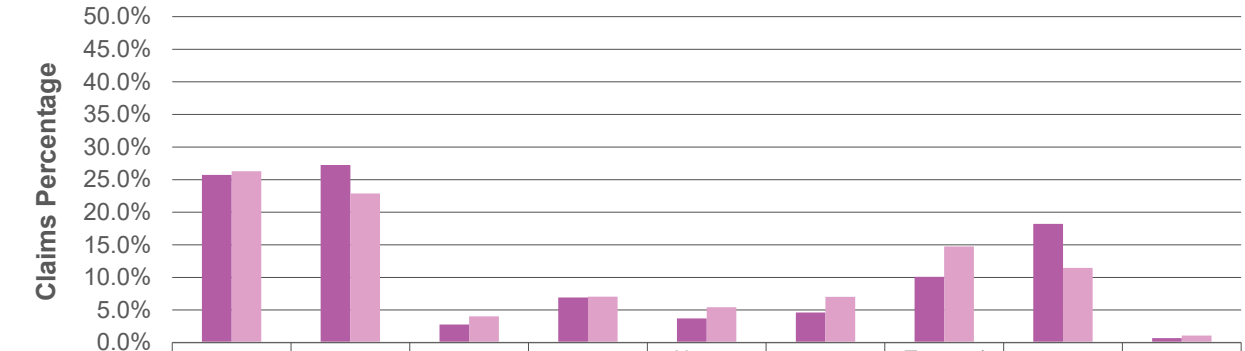
San Diego MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	29.6%	21.2%	2.9%	8.2%	4.7%	8.7%	12.0%	10.0%	2.8%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020

San Diego MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	25.7%	27.2%	2.8%	6.9%	3.7%	4.6%	10.1%	18.2%	0.7%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

The MHP saw a significant decrease in the number of beneficiaries requiring hospitalization as well as the total inpatient admissions since CY 2018.

The statewide average length of stay rose steadily from CY 2018 to CY 2020. San Diego's LOS has fluctuated over time; it first went down from CY 2018 to CY 2019 and then went up from CY 2019 to CY 2020.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

San Diego MHP							
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	3,809	9,658	8.52	8.68	$10,409	$11,814	$39,646,166
CY 2019	3,988	10,432	7.95	7.80	$9,332	$10,535	$37,216,651
CY 2018	5,287	13,893	9.74	7.63	$12,801	$9,772	$67,679,794

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

The MHP's percentage of HCB's at 2.92 percent is less than the state average of 4.07 percent, while the average approved claim per HCB ($52,510) is slightly lower than the state average ($53,969). San Diego's percentage of approved claims going towards HCB's has come down from almost one third of claims in CY 2018 and was a little more than one in four claims in CY 2020.

Table 8: HCB CY 2018-20

San Diego MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	1,038	35,583	2.92%	$52,510	$54,504,986	26.60%
	CY 2019	750	35,495	2.11%	$51,557	$38,668,116	23.09%
	CY 2018	1,020	37,692	2.71%	$61,786	$63,022,096	32.48%

See Attachment D, Table D2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Retention Data

Like the statewide data (25.19 percent), about one quarter (27.41 percent) of beneficiaries served received one to four services. The remaining three quarters received five or more services.

Table 9: Retention of Medi-Cal Beneficiaries CY 2020

	San Diego			STATEWIDE			
Number of Services Approved per Medi-Cal Beneficiary Served	# of Medi-Cal beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	3,015	8.47	8.47	9.76	9.76	5.69	21.86
2 Services	2,404	6.76	15.23	6.16	15.91	4.39	17.07
3 Services	2,061	5.79	21.02	4.78	20.69	2.44	9.17
4 Services	2,273	6.39	27.41	4.50	25.19	2.44	7.78
5-15 Services	11,691	32.86	60.26	29.47	54.67	19.96	42.46
>15 Services	14,139	39.74	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The decrease in the number of beneficiaries requiring hospitalization as well as the total inpatient admissions since CY 2018 is another positive indicator regarding the MHP's

attention to hospitalization and post-hospitalization care. This might also factor into the MHP's HCB percentage being lower than the state average.

The emphasis on the most acute level of care might have limited the resources available for beneficiaries seen for lower-level chronic issues. This is borne out by the MHP's report that 51 percent of initial adult encounters are for emergency and crisis care.

Workforce shortages continue to make it difficult to transition beneficiaries to the appropriate level of care.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's quality assessment and performance improvement program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: "Preventing Crisis Service and Inpatient Utilization among Youth with Depression"

Date Started: March 2020

Aim Statement: Among all housed youth ages 12-17 with depression who receive outpatient care between November 30, 2020, and September 30, 2021, will the average number of crises visits or the average number of inpatient hospitalization visits during the youths' treatment episodes be at least one point lower for youth who receive the Three Session Sleep Intervention in comparison to youth who do not receive the intervention?

[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Target Population: Housed youth ages 12-17 with depression who receive outpatient care between November 30, 2020, and September 30, 2021.

Validation Information: The MHP's clinical PIP is in the second remeasurement phase and considered completed.

Summary

The improvement strategy was a 3-session sleep disturbance therapeutic intervention for housed youth ages 12-17 with diagnoses of depression. A pre and post discharge Patient-Reported Outcomes Measurement Information System (PROMIS) and CANS measured change in symptoms of depression and change in symptoms of sleep problems. Utilization of crisis services/inpatient hospitalization was also monitored.

Thirteen youth completed a pre and post PROMIS. Nine of the thirteen youth (69 percent) showed a 4-point decline on the PROMIS Sleep Disturbance Assessment between intake and discharge which was defined as a clinically significant change.

Forty-two youth who received the 3-session sleep disturbance intervention were discharged with a pre and post CANS and were matched to a control group. The treatment group evidenced zero crisis / inpatient hospitalizations. The control group evidenced two youth that received crisis services and an inpatient hospitalization. Change in symptoms of depression results evidenced 62 percent of the treatment group showed improvement from intake to discharge vs. 50 percent of the control group. A Chi-square analysis was not statistically significant. Change in symptoms of sleep problems results evidenced 50 percent of the treatment group showed improvement from intake to discharge vs. 33 percent of the control group. A Chi-square analysis was not statistically significant.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because, although the findings were promising, the small sample size and statistical analysis was not significant.

The TA provided to the MHP by CalEQRO consisted of:

- CalEQRO provided TA throughout the year to assist in the implementation of the PIP, including barriers of COVID-19 pandemic that interfered with process of the PIP as intended in initial design.

CalEQRO recommendations for improvement of this clinical PIP include:

- There are no further recommendations for this PIP as it is complete.

- CalEQRO recommends that the MHP engage in PIP TA early and often while developing and implementing the new clinical PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Connections after a PERT Contact"

Date Started: February 2020

Aim Statement: Will a peer-specialist based linkage program increase the rate of connection to appropriate mental health services within 30 days of a PERT contact for clients who refuse services at the time of the PERT contact or have not connected with services within 60 days of the PERT contact. Rates of connection measured will be threefold: (1) engagement with Peer/Family Support Specialist, (2) successfully establishing an appointment for services, (3) attending the scheduled appointment.

Target Population: Adults who initially refuse services during a PERT contact and have not accessed SDCBHS services in the last 60 days. Exclusion criteria include the following: under the age of 18, violent, unpredictable tendencies; or adults experiencing a 5150 hold during their PERT contact (unless deemed appropriate to refer to the Peer Support Specialist (PSS) by the PERT clinician).

Validation Information: The MHP's non-clinical PIP is in the second remeasurement phase and considered completed.

Summary

PERT contacts often end up having repeat encounters with PERT services resulting in increased usage of PERT and other emergency services as well as inpatient hospitalization. Linking contacts with services by means of a PSS intermediary may help break the cycle or PERT/emergency usage. PERT clinicians connect eligible contacts through a warm handoff to a peer or family support specialist. The warm hand-off was to consist of in-person at a PERT contact, over the phone at a PERT contact, or the PERT clinician collecting client's contact information and gaining permission to provide it to the PSS for follow-up. Implementation coincided with the onset of COVID-19 restrictions. Implementation was reduced to third level of contact; PERT clinician describing the intervention and obtaining consent to provide the PSS with their contact information.

Seventeen PERT contacts consented to a referral to a PSS. Three were connected to the PSS, to services, and had no further PERT contacts. The PSS were not able to contact fourteen PERT contacts. Of the fourteen, ten had no further PERT contacts, three had one or more PERT contacts, and one had inpatient and jail services. The small sample size rendered outcomes that were not statistically significant.

TA and Recommendations

As submitted, this non-clinical PIP was found to have no confidence, because the exclusion criteria reduced the population served to seventeen PERT contacts. The referral to PSS, and not a direct connection, further reduced the population served to three PERT contacts. The methodology proved to be ineffective.

The TA provided to the MHP by CalEQRO consisted of:

- CalEQRO provided TA throughout the year to assist in the implementation of the PIP, including barriers of COVID-19 pandemic that interfered with process of the PIP as intended in initial design.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- There are no further recommendations for this PIP as it is complete.

INFORMATION SYSTEMS (IS)

BACKGROUND

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's EHR, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

IS IN SAN DIEGO COUNTY

California MHP EHRs fall into two main categories -- those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP for managing outpatient care is Cerner Community Behavioral Health, which has been in use for 13 years. San Diego County Psychiatric Hospital (SDCPH) converted to the CM EHR in December 2020. Currently, the MHP is actively implementing the CM EHR in the outpatient care facilities which requires heavy staff involvement to fully manage. The MHP is actively recruiting 12 additional contractors to work on the implementation.

Approximately 7.2 percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The budget percentage went down this past year because the initial expenditure for the CM EHR was realized as part of the SDCPH CM implementation.

The MHP has 4,460 named users with log-on authority to the EHR, including approximately 610 county-operated staff and 3,850 contractor-operated staff. Support for the users is provided by 10 full-time equivalent (FTE) IS technology positions.

As of the FY 2021-22 EQR, all outpatient contract providers have access to directly enter clinical data into the MHP's EHR. Inpatient contract provider beneficiaries and services are entered by MHP staff. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☐	Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☒	Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☒ Monthly	100%
☐	Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☐	Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP plans to implement a beneficiary PHR this year as part of the CM implementation.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with mental health CBO/Contract providers, Whole Person Care providers, and Hospitals.

IS KEY COMPONENTS

CalEQRO identifies the following key components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in

extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 11: Key Components – IS Infrastructure

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Partially Met
4F	Interoperability	Met

Strengths and opportunities associated with the IS components identified above include:

- The county has a robust platform, HealtheIntent, for reporting and data analysis where they consolidate data from disparate sources to develop a longitudinal patient record. This platform currently ingests data from CCBH and CM and is in development to ingest other disparate systems. The MHP used HealtheIntent to build a COVID-19 dashboard to identify unvaccinated beneficiaries.
- HealtheIntent contains built in data integrity tools.
- Wherever possible, the MHP uses telehealth rather than telephone services. American Rescue Plan money was used to purchase devices for provider and beneficiary use to achieve a high level of services provided by telehealth.
- At 1.51 percent, the MHP's Medi-Cal claims denial rate is less than half of the state 3.19 percent average.
- The MHP should consider developing processes to maintain a formal record of user attendance and completion of security training activities to ensure that all staff are trained on cyber-security protocols.
- Following the CM implementation, the MHP should consider developing processes that will allow contract providers with their own EHR's to use electronic batch file transfer or electronic data interchange to submit data into the MHP EHR.

IMPACT OF FINDINGS

The MHP has a sophisticated IS department that utilizes contracted services to expand their scope of activities. Optum provides day-to-day reporting, training, and helpdesk functions and maintains a well-organized website for both MHP and contracted providers. UCSD expands the clinical informatics and research capabilities of the MHP.

The MHP successfully converted the SDCPH to the CM EHR during a worldwide pandemic and has made significant progress with its goal to convert all outpatient facilities to CM within the year. They are planning to convert all facilities on the same day. This approach could be less costly and have a shorter implementation timeline, but it carries a higher degree of risk than a phased implementation. The MHP will need expansive communications and training programs and extensive helpdesk personnel to support over 4,000 users for the cutover, as well as detailed conversion and risk management plans to address the problems that might occur. At the same time, it is important that all providers and current EHR system users are aware of the upcoming changes and their responsibilities to make the project a success.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP collects the state mandated CPS and when scored by DHCS and returned to them, they are reviewed for possible programmatic changes. The most recent CPS was used to determine if beneficiaries and families had access to written information in their primary language and/or received services in the language they prefer.

CONSUMER FAMILY MEMBER FOCUS GROUP

Consumer and family member (CFM) focus groups are an important component of the CalEQRO site review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-site planning process, CalEQRO requested two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via zoom and included three participants; no language interpreter was used for this focus group. All consumers/family members confirm that they receive/have a family member who receives clinical services from the MHP.

All participants reported that the initial entry into services was timely, and that the MHP assisted them in accessing services. The time between appointments is approximately

once a month for psychiatrists, and weekly for clinical therapy and other meetings, or as needed. This includes primary physician as needed and case managers who are available to the participants. The participants agreed that there is a sufficient frequency of services. None of the participants had a problem with remote telehealth meetings and confirm they are the same length as the face-to-face meetings. The participants reported that they have the choice of face-to-face, telehealth or telephone for most services. There was general agreement among participants that they knew what to do if they missed an appointment, and that they do receive text messages or reminder calls prior to appointments. All participants were aware of a warm line, peer partners, and ways to reach out if in crisis. The participants agree that their clinical therapists talk about their overall health with them. All participants felt the staff were supportive and addressed their cultural and linguistic needs. None of the participants use the MHP website. The participants are aware of, and prior to COVID-19 restrictions, have utilized the San Diego Mental Health Clubhouses. All participants agreed that the staff involves them in their treatment planning and give them a sense hope and belief in their recovery. It was also noted that the participants have the opportunity to either volunteer or get paid for work within behavioral health system.

Recommendations from focus group participants included:

- It would be useful to have more groups, especially arts and crafts.
- Ensure that clubhouses with a high Spanish speaking population have Spanish speakers or translation services available.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parent/caregivers of children currently receiving services, mostly beneficiaries who initiated services in the preceding 12 months. Although the MHP invited and had confirmation from several beneficiaries, CalEQRO did not conduct a second CFM Focus Group as no participants showed for the meeting.

IMPACT OF FINDINGS

Overall, the participants seem pleased with their services and had no unmet needs. Although there were only three participants, they were from different programs and therefore gave a view into beneficiary perceptions from distinct parts of the system of care. The participants remarked on receiving help with employment to enhance their recovery, and all find staff supportive and helpful in problem solving issues of treatment or recovery.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP has a public health approach to providing services, focusing on epidemiology, behavioral and physical health integration, and health equity.

   (Access)

2. The MHP telehealth service delivery system provides beneficiary hardware and usage assistance; captures video telehealth as separate and distinct from telephonic services; prioritizes beneficiary empowerment and choice in deciding face-to-face or telehealth options; and uses a safety and clinical decision-making framework to determine use and frequency of telehealth utilization.

   (Access)

3. This past year the MHP has improved throughput for the continuum of crisis care and urgent access by increasing Crisis Stabilization Units (now three); North Coast and Regional Mobile Crisis Response Teams began offering services; and, increased Acute and Long-Term Care beds.

   (Access)

4. The MHP evidenced rehospitalization rates at 7- and 30-days, which is significantly lower than the state (7-day, 7 percent to 19 percent and 30-day 12 percent to 28 percent).

   (Timeliness)

5. The MHP evidenced active bidirectional communication and coordinated relationships with all scopes of practice in their QIC, PIPs, administrative developments and clinical practice process developments: including administrative staff, physicians, nursing, IT, clinicians, peers and researchers.

   (Quality)

6. Despite considerable changes and COVID-19, the MHP maintained diligence with the EHR implementation.

   (Information Systems)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's providers evidence wait-lists, up to weeks, for direct outpatient children's and adult service requests that are not a step down from urgent or emergent delivery systems.

   (Access)

2. The ATA report, provided by the MHP, showed that the range in most areas of timeliness was longer than would be expected, and this suggests waitlists for some services. The MHP evidenced extensive timeliness ranges for first non-urgent service request; first non-urgent rendered service request; first non-urgent request to first offered psychiatric appointment; and first non-urgent rendered first offered psychiatric appointment for all, adults, children, and foster care youth. Of the sixteen ATA unique timeliness measures the MHP reported ranges of: 200-299 days (3); 300-399 days (3); 400 or more days (4).

   (Timeliness)

3. The MHP would benefit from more bidirectional communication with the CBO's and standardization of the contract monitoring process.

   (Quality)

4. The QI Program Work Plan Evaluation does not provide an analysis or develop future recommendations utilizing a QAPI process. The evaluation of unmet goals is to continue to monitor with the intention of meeting the goal in the future.

   (Quality)

5. There is a need for regular updates throughout the San Diego MHP network on the progress and status of the upcoming CM outpatient implementation.

   (Information Systems)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve beneficiary outcomes:

1. Investigate the reasons, develop, and implement strategies, and improve wait lists for direct outpatient children and adult services requests that are not a step down from urgent or emergent delivery systems.

   (Access)

2. Investigate reasons, develop, and implement strategies, and improve timeliness to first non-urgent service request; first non-urgent rendered service request; first

non-urgent request to first offered psychiatric appointment; and first non-urgent rendered first offered psychiatric appointment for all, adults, children and foster care youth.

(Timeliness)

Continue efforts to improve bidirectional communication with the CBO's and standardization of the contract monitoring process. (This recommendation is a follow-up from FY 2020-21.)
(Quality)

3. Investigate reasons, develop strategies, and improve the QI Program Work Plan Evaluation analysis and future recommendations utilizing a QAPI process. Analyze the reasons, develop a plan, and write this into workplan to implement.

   (Quality)

4. Develop detailed testing, training, data conversion, integration, support and risk-management plans to support the outpatient cutover to the CM EHR. Ensure that all providers (CBO, Network and County) receive regular updates on the status of the project and that a wide range of providers are represented in all remaining phases of the project.

   (Information Systems)

SITE REVIEW BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

San Diego
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Community-Based Services Agencies Group Interview
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer

Bill Walker, Quality Reviewer

Zena Jacobi, Information Systems Reviewer

Pamela Roach, Consumer/Family Member Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Adame	Brianna	Clinician	Telecare Tesoro
Anderson	Kathi	Executive Director	Survivors of Torture, International
Anderson	Nicole	Clinical Director	Community Research Foundation (CRF) ACT Programs
Baetiong	Winona	Senior Mental Health Specialist	Survivors of Torture, International
Barounis	Kya	Senior Mental Health Researcher	UC San Diego Child and Adolescent Services Research Center (CASRC)
Barsoom	Alejandra	Psychosocial Rehabilitation Specialist	CRF Intensive Mobile Psychosocial Assertive Community Treatment (IMPACT)
Bedford-Saldana	Alyce	Senior Vice President	Mental Health Systems
Bergmann	Luke	Director	SDCBHS
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum
Canizales	Alicia	Social Worker 1 (ASW), OP Psych	Rady Children's Hospital
Carroll	Theresa	Clinical Supervisor	Downtown IMPACT and Senior IMPACT
Castaneda	Tania	Peer Support Specialist	unknown
Castaneda	Stephanie	Mental Health Case Management Clinician	East County Mental Health Center
Chadwick	Amy	System of Care Evaluation Coordinator	CASRC
Collier	Ashley	Case Manager II	Telecare Agewise Institutional Case Management (ICM)
Conlow	AnnLouise	Program Coordinator	SDCBHS – Management Information Systems
Cooper	Fran	Assistant Medical Services Administrator	SDCBHS – Children, Youth, and Families System of Care (SOC)
Crandal	Brent	Director, Behavioral Health Quality Improvement	Rady Children's Hospital – San Diego
Dahlstedt	Drew	CFO/COO/Licensee	Varsity Short-Term Residential Therapeutic Program
Davenport	Dayjahnay	Peer Support Specialist	CRF

Last Name	First Name	Position	Agency
Davies	Christine	Assistant Program Director, PERT	Community Research Foundation
Delapena	Minda	Entitlement Specialist	IMPACT
Demateo	Danielle	Unknown – did not register with SDCBHS	Unknown – did not register with SDCBHS
Esposito	Nicole	Assistant Clinical Director	SDCBHS – Clinical Director's Office
Esposito	Nicole	Chief Population Health Officer	SDCBHS
Evans Murray	Cara	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult SOC
Flores	Madeline	Clinician	Palomar Family Counseling Service
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	SDCBHS – Adult and Older Adult SOC
Garcia	Lidia	Clinician	East Region School-Based, East County Clinic
Glezer	Natanya	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Guevara	Christopher	Principal Administrative Analyst	SDCBHS – Management Information Systems
Guingab	Amelia	Principal Administrative Analyst	SDCBHS – Fiscal
Hammond	Linda	President & CEO	Community Research Foundation
Hansen	Pam	Senior Director of Specialty Clinical Programs	Center for Children
Hayes	Skylar	Reporting and Application Development Manager	Optum
Higgins	Alan	Data Analyst II	Optum
Hoff	Megan	Clinician	North County Lifeline
Holder	Judi	Recovery Services Administrator II	Recovery Innovations, Inc.
Jami	Feroozan "Farrah"	Program Administrator	Telecare Agewise SBCM & ICM
Jones	Cierra	Case Manager II – Housing	Telecare Tesoro

Last Name	First Name	Position	Agency
Kattan	Jessica	Medical Consultant	SDCBHS – Inpatient Health Services
Kemble	Derek	Administrative Analyst III	SDCBHS – Quality Improvement, Performance Improvement Team
Kiviat Nudd	Aurora	Assistant Director and Chief Operations Officer	SDCBHS
Knight	Betsy	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Koenig	Yael	Deputy Director, Children, Youth and Families System of Care	SDCBHS – Children, Youth, and Families SOC
Kohler	Richard	Executive Director	Center for Positive Changes
Krelstein	Michael	Chief Medical Officer	SDCBHS – Clinical Director's Office
Lagare	Tiffany	Research Associate	CASRC
Lance Sexton	Amanda	Assistant Medical Services Administrator	SDCBHS – Children, Youth, and Families SOC
Lang	Tabatha	Assistant Medical Services Administrator	SDCBHS – Quality Improvement
Loyo-Rodriguez	Raul	Department Budget Manager	SDCBHS
Lucas	Lavonne	Medical Claims Manager	SDCBHS
Marvin	Mark	Vice President, PERT	Community Research Foundation
McDonald	Kate	Senior Mental Health Researcher	CASRC
McPherson	Julie	Vice President, CYF	Community Research Foundation
Mercado	Marcela	Community Assistant II	Southeast Prevention Early Prevention Program, San Diego Unified School District
Miles	Liz	Principal Administrative Analyst	SDCBHS – Quality Improvement, Performance Improvement Team
Miller	Shawntay	Case Manager II	Telecare La Luz
Mockus-Valenzuela	Danyte	Health Planning and Program Specialist	SDCBHS – Prevention and Community Engagement
Murguia	Krystle	Administrative Analyst III	SDCBHS – Quality Improvement, Performance Improvement Team
Nacario	Cathryn	Chief Executive Officer	National Alliance on Mental Health (NAMI)

Last Name	First Name	Position	Agency
Nelson	Stephen	Peer Support Specialist	Serial Inebriate Program
Panczakiewicz	Amy	Senior Evaluation Research Associate	UC San Diego Health Services Research Center (HSRC)
Parson	Heather	Behavioral Health Program Coordinator	SDCBHS – Quality Improvement, Quality Management
Pauly	Kimberly	Chief, Agency Operations	SDCBHS
Penfold	Bill	Senior IT Manager	Optum
Ponzo	John	Mental Health Case Management Clinician	Enhanced Care Coordination
Pratt	Nikole	Peer Support Specialist	Interfaith Services
Privara	Nadia	Acting Assistant Director, Chief Strategy & Finance Officer	SDCBHS
Quach	Phuong	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Ramirez	Ezra	Administrative Analyst II	SDCBHS – Quality Improvement, Performance Improvement Team
Ramos	Nilanie	Chief, Agency Operations	SDCBHS – Clinical Director's Office
Roberts	Kisa	Licensed Mental Health Clinician	East County Mental Health Center
Rojas	Danielle	MHRS	Telecare La Luz
Rucker	James	Peer Support Specialist	unknown
Rule	Katherine	Project Manager	HSRC
Sampson	Lauren	Substance Abuse Specialist (provides MH services)	Downtown IMPACT
Sarkin	Andrew	Director of Evaluation Research	HSRC
Solomona	Sira	Clinician	New Alternatives
Stanczak	Esther	Clinical Director	Telecare La Luz & Tesoro
Stark	Tamara	Senior Vice President, San Diego Programs	Exodus Recovery
Stern-Ellis	Heidi	Clinical Improvement Coordinator	Rady Children's Hospital San Diego-Chadwick Center KidSTART Program

Last Name	First Name	Position	Agency
Strout	Elizabeth	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Tally	Steve	Assistant Director of Evaluation Research	HSRC
Thornton-Stearns	Cecily	Assistant Director and Chief Program Officer	SDCBHS
Tillotson	Stephanie	Social Worker 1 (ASW), OP Psych	Rady Children's Hospital
Tran	Anh	Research Associate	CASRC
Turov	Joshua	Associate Director, School-Based FSP	North County Lifeline
Underhill	Alison	Field Operations Supervisor, PERT	Community Research Foundation
Velasquez Trask	Emily	Senior Mental Health Consultant	CASRC
Vleugels	Laura	Supervising Psychiatrist	SDCBHS – Children, Youth, and Families SOC
Webber	Mercedes	Peer Support Specialist (volunteer)	North Central Outpatient Clinic
White-Voth	Charity	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult SOC
Wickens	Bryan	Assistant Program Director	CRF Vista Balboa Crisis Center
Woodridge	Kathy	MHRS	Telecare Agewise SBCM
Wren	Jennifer	Social Worker 1 (ASW), OP Psych	Rady Children's Hospital
Zauner	Cassandra Ann	Peer Support Specialist (volunteer)	North Central Outpatient Clinic

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☒ →Low confidence ☐ →No confidence	As submitted, this clinical PIP was found to have low confidence, because although the findings were promising the small sample size or statistical analysis was not significant.

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: San Diego County Behavioral Health Services
PIP Title: "Preventing Crisis Service and Inpatient Utilization among Youth with Depression"
PIP Aim Statement: Among all housed youth ages 12-17 with depression who receive outpatient care between November 30, 2020, and September 30, 2021, will the average number of crisis visits or the average number of inpatient hospitalization visits during the youths' treatment episodes be at least one point lower for youth who receive the Three Session Sleep Intervention in comparison to youth who do not receive the intervention?
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Housed youth ages 12-17 with depression who receive outpatient care between November 30, 2020, and September 30, 2021

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Receive 3-Session Sleep Intervention and incorporate the suggestions
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Implement 3-Session Sleep Intervention
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) n/a

Performance measures (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Timeliness of first assessment appointment	*Q1 -Q2 7/20-12/20*	*n=505 72% Average 14 business days*	*11/1/2021*	*N=13 9 (69%)*	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
PM 1. Decrease symptoms of sleep problems-PROMIS Sleep Disturbance Assessment	7/14/2021	*N=6 4 (67%)*	*11/1/2021*	*N=13 9 (69%)*	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
PM 1.1 Decrease symptoms of sleep problems-CANS Assessment	n/a	n/a	*10/15/2021*	*TSSI Participants (n=42) At least one point decline on the CANS sleep item: 21 (50%)*	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
				Matched Control Group Participants (n=42) *At least one point decline on the CANS sleep item: 14 (33%)*		
PM 2. Decrease use of crisis services and inpatient hospitalization	n/a	n/a	*10/15/2021*	***TSSI Participants (n=42)*** Average number of crisis visits=0 Average number of inpatient hospitalizations=0 ***Matched Control Group Participants (n=42)*** Average number of crisis visits =.05 (2/42) Average number of inpatient hospitalizations=.05 (2/42)	☐ Yes ☐ No n/a: Total Ns too small for statistical analysis	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: No recommendations as this PIP is completed.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☐ →Low confidence ☒ →No confidence	There was not enough data to analyze. The exclusion criteria reduced the population served to 17 PERT contacts. The referral to PSS, and not a direct connection, further reduced the population served to three PERT contacts. The methodology proved to be ineffective.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: San Diego County Behavioral Health Services	
PIP Title: "Connections after a PERT Contact"	
PIP Aim Statement: Will a peer-specialist based linkage program increase the rate of connection to appropriate mental health services within 30 days of a PERT contact for clients who refuse services at the time of the PERT contact or have not connected with services within 60 days of the PERT contact. Rates of connection measured will be threefold: (1) engagement with Peer/Family Support Specialist, (2) successfully establishing an appointment for services, (3) attending the scheduled appointment**.**	

Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)

☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)

☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases)

☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)

Target age group (check one):

☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children

*If PIP uses different age threshold for children, specify age range here:

Target population description, such as specific diagnosis (please specify):

Adults who initially refuse services during a PERT contact and have not accessed SDCBHS services in the last 60 days. Exclusion criteria include the following: under the age of 18,violent, unpredictable tendencies; or adults experiencing a 5150 hold during their PERT contact (unless deemed appropriate to refer to the Peer Support Specialist (PSS) by the PERT clinician).

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

n/a

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

Inclusion of a direct connection from a PSS after a PERT contact

MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

n/a

Performance measures (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
There was not enough data to analyze. The exclusion criteria reduced the population served to			☐ Not applicable—PIP is in Planning or implementation		☐ Yes ☐ No	There were 17 clients referred to the PSS by the PERT clinicians. Of those 17, only 3

Performance measures (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
seventeen PERT contacts. The referral to PSS, and not a direct connection, further reduced the population served to three PERT contacts. The methodology proved to be ineffective.			phase, results not available			were able to be contacted by the PSS: 2 had no further services and 1 had OP services. Of the 14 clients the PSS did not engage:10 had no further services; 2 had 1 or more PERT services, 1 had OP services followed by 2 repeat PERT visits and 1 had IHOT services followed by IP and jail.

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☒ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP: This PIP is completed. There was not enough data to analyze. The exclusion criteria reduced the population served to seventeen PERT contacts. The referral to PSS, and not a direct connection, further reduced the population served to three PERT contacts. The methodology proved to be ineffective.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

San Diego MHP					
Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Large	1,859,411	68,297	3.67%	$419,802,216	$6,147
MHP	267,688	11,052	4.13%	$61,236,509	$5,541

Table D2: CY 2020 Distribution of Medi-Cal Beneficiaries by ACB Range

San Diego MHP								
ACB Range	MHP Medi-Cal Beneficiaries Served	MHP Percentage of Medi-Cal Beneficiaries Served	Statewide Percentage of Medi-Cal Beneficiaries Served	MHP Total Medi-Cal Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Medi-Cal Claims	Statewide Percentage of Total Approved Medi-Cal Claims
<$20K	33,605	94.44%	92.22%	$127,636,532	$3,798	$4,399	62.28%	56.70%
$20K-$30K	940	2.64%	3.71%	$22,783,139	$24,237	$24,274	11.12%	12.59%
>$30K	1,038	2.92%	4.07%	$54,504,986	$52,510	$53,969	26.60%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

San Diego MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**24,744**	**767,770**	**$176,513,484**	**8,985**	**$2,668,477**	**1.51%**	**$173,845,007**
JAN20	2,230	64,767	$15,272,968	573	$168,387	1.10%	$15,104,581
FEB20	2,237	60,296	$14,425,536	610	$187,033	1.30%	$14,238,503
MAR20	2,154	63,340	$15,540,978	509	$228,376	1.47%	$15,312,602
APR20	2,348	66,876	$14,589,347	622	$168,826	1.16%	$14,420,521
MAY20	2,107	65,764	$15,539,333	840	$272,351	1.75%	$15,266,982
JUN20	2,103	63,570	$15,230,258	770	$240,307	1.58%	$14,989,951
JUL20	2,122	65,788	$14,390,601	776	$201,708	1.40%	$14,188,893
AUG20	1,802	62,535	$14,082,268	856	$271,040	1.92%	$13,811,228
SEP20	2,091	65,759	$14,583,556	862	$239,734	1.64%	$14,343,822
OCT20	2,249	67,981	$15,327,058	903	$225,997	1.47%	$15,101,061
NOV20	1,617	58,659	$13,427,274	782	$210,039	1.56%	$13,217,235
DEC20	1,684	62,435	$14,104,305	882	$254,679	1.81%	$13,849,626

Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30th, 2021. Only reports Short-Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.

Table D4: Summary of CY 2020 Top Five Reasons for Medi-Cal Claim Denial

San Diego MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	3,538	$1,127,297	42%
Beneficiary not eligible	2,586	$815,946	31%
Medicare Part B or Other Health Coverage must be billed before submission of claim	1,727	$478,961	18%
Beneficiary not eligible or non-covered charges	869	$193,870	7%
Service Facility Location provider NPI is not eligible to provide this service	97	$13,424	1%
TOTAL	**8,817**	**$2,629,498**	**99%**